Mail to: STATE OF ALABAMA
Workers' Compensation Division
Department of Industrial Relations
Montgomery, Alabama 36131

The original of this form must be filed with this office. Copies will not be accepted.
The use of this form is required under the provisions of the Alabama Workers' Compensation Law.

CLAIM SUMMARY FORM

PLEASE TYPE OR PRINT

SUSPENSION_____ **SETTLEMENT**_____ **AMENDED**_____

1. Employee_____ 2. S.S.N._____
3. Employer_____ 4. Unemployment Compensation #_____
5. Date of Injury_____ 6. Date disability began this period_____
7. Insurance carrier_____ 8. Claim #_____ 9. Service Co. #_____
10. Name, address and telephone number of office filing this report_____

_____

(DO NOT INCLUDE ANY PAYMENTS PREVIOUSLY FILED ON A CLAIM SUMMARY FORM)

11. Dates Last day comp paid_____ RTW_____ MMI_____
12. Did claimant work during this period of disability? Y/N If so, from _____ to _____ for total days_____.
13. AWW_____ CR (66.67%)_____ 14. Medical pd this period_____
15. Amount and type of comp paid:

TTD $_____ WKS_____ Days_____
TPD $_____ WKS_____
PPD $_____ WKS_____ Days_____ %_____ POB_____
PTD $_____ WKS_____ Days_____
Death $_____ WKS_____ Days_____

Estate Pymt $_____ Burial Pymt $_____ Future Med $_____
LSP $_____ Date Pd_____ WKS_____ Days_____
%_____ Part of Body_____

16. Ombudsman Y/N Court CV# _____ Location (county) _____
17. Legal: Pltf Fees $_____ Exp $ _____ Def Fees $_____ Exp $_____

Date_____ Signature and Title_____

WC 4 Revised 5-95